YOUR MEDICARE PLAN COMPARISON

LOCAL HELP FOR PEOPLE WITH MEDICARE

*******IMPORTANT******* **If you have a www.medicare.gov account, provide the login info here: USER NAME_____PASSWORD_____*Check to see if it's active and working properly. If you do not have an account, we will create one for you and send you the info with your Plan Comparison report.**

PLEASE PRINT

Name_____Date of Birth ___ |__ |____ Age ____

Address_____ Zip Code_____

(Street) (Town) (State)

Day time Phone #_____Email Address_____

INFORMATION ON YOUR RED, WHITE & BLUE MEDICARE CARD:

Medicare Number:_____

Note: There is no letter O; they are zeros

Coverage Start Date: HOSPITAL (Part A) _____ MEDICAL (Part B) _____

Name of pharmacy that you use: _____

Would you consider changing pharmacies if you could save on costs? Yes __ No __

Would you consider using a mail order pharmacy, if you could save on costs? Yes __ No __

Are you a Veteran? Yes __ No __

Are you enrolled in MassHealth (Medicaid)? Yes __ No __

Do you receive Extra Help (LIS)? Yes __ No __

Are you enrolled in Prescription Advantage? Yes __ No __ I don't know what that is ___

Your current insurance coverage (complete what is applicable):

Employer Group Health Plan Name of Insurance Co: _____

Medigap Plan Name of Insurance Co: _____

Type of Medigap: Core____ Medigap 1A____ Medigap 1____

Medicare Part D Plan Name of Plan: _____

Medicare Advantage Plan (Part C) Name of Plan: _____

GIC/Federal or Employer Retiree Plan Name of Plan: _____

If you have a Retiree Plan, does it provide prescription coverage? Yes ____ No____ N/A____

OPTIONAL: You may be eligible for benefit programs that can help with your health care costs. If you provide information below, we will screen for benefit eligibility*:

Your (and spouse if applicable) monthly **gross** income*:

Your monthly income: $_____ **Spouse monthly income**: $_____ **N/A**_____

*Assets may also be a factor of eligibility.

We will inform you of the asset limits if it appears you may be eligible for benefit programs based on income listed.

Provide your list of medications on the other side of sheet →

PRINT CLEARLY OR ATTACH A PRINTED LIST (Your pharmacist will print if you need assistance).
IF MEDICATION MUST BE BRAND ONLY, PLEASE NOTATE. OTHERWISE GENERIC IS ASSUMED.

DRUG NAME Spell exactly as written on the bottle/pkg **Ex**: Lipitor or Atorvastatin	**DRUG FORM** **Ex:** Tab, Cap, Inj, Pen, Cream, Ointment, Lotion, Sol, Spray, Patch, etc.	**DRUG STRENGTH/DOSAGE** **Ex:** 10 Mg. – one per day	**HOW OFTEN DO YOU FILL THIS DRUG?** **Ex:** Monthly, Every 3 mos, 6 mos, 1x/year
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2.			
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Mail this completed form to:
Rockport COA
ATTN: SHINE
58 Broadway
Rockport, MA 01966

This area for SHINE office use:
Notes_____
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